Quarterly Surveillance Report

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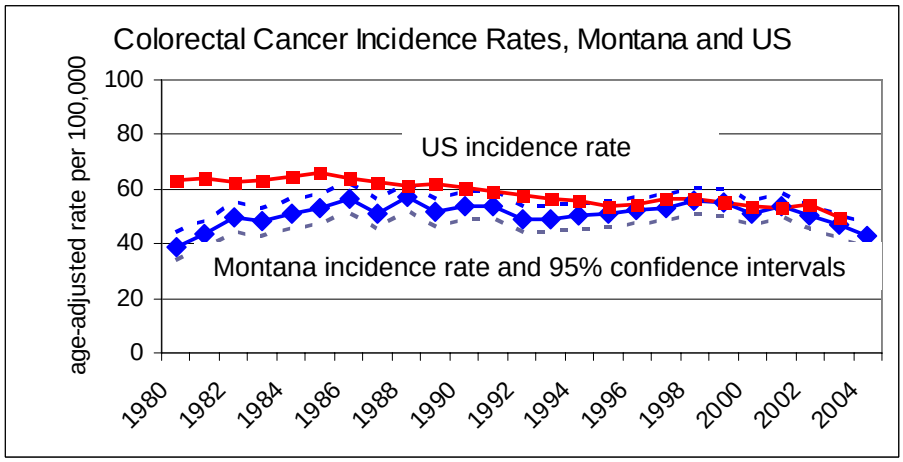
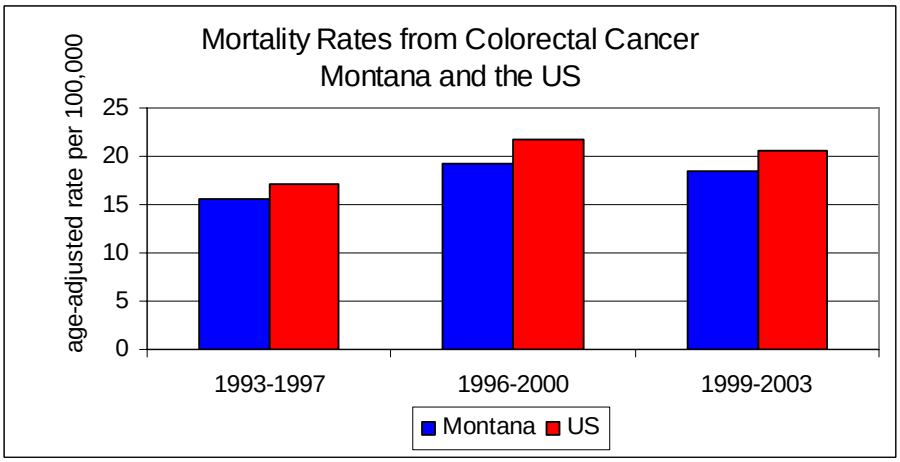
Colorectal Cancer

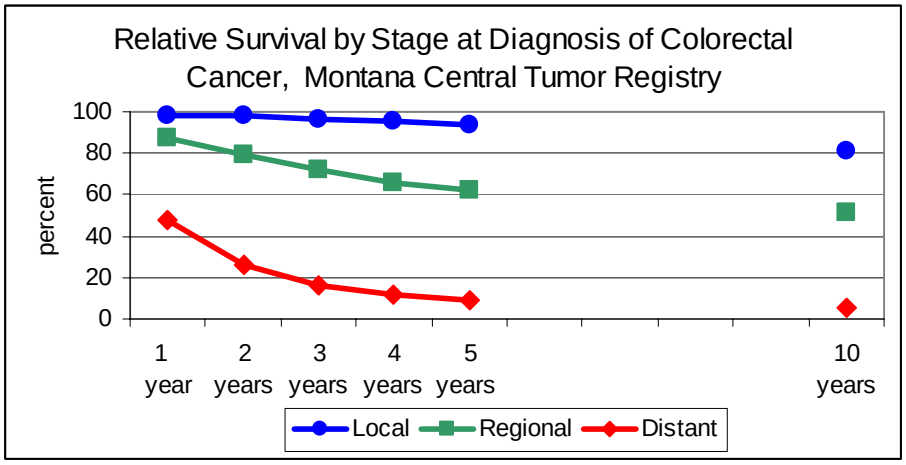
Colorectal cancer is the fourth most common newly diagnosed cancer in Montana, accounting for 11% of incident cancers, after prostate (19%), breast (15%) and lung (15%). Although there might appear to be a trend toward increasing incidence from 1980 through 1988, and again from 1992 through 2000, these trends are not statistically significant. The incidence rate in Montana was lower than the national rate until the mid-1990s; it is now similar to the national rate because the national rate declined between 1980 and 1995.



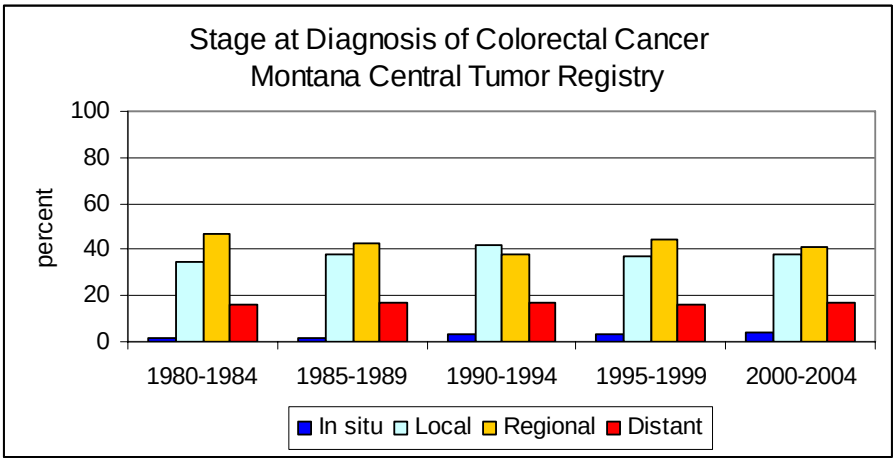
Colorectal cancer is the fourth most common cause of death from cancer in Montana, causing 18.4 deaths per 100,000 population, compared to lung (53.6/100,000), prostate (29.4/100,00) and breast (23.7/100,000) cancers. Mortality from colorectal cancer in Montana remains slightly below the national rate.



Screening and early detection might reduce the mortality from colorectal cancer by nearly half.[1] Because most colon cancer arises first as a polyp, colonoscopy and polyp removal may prevent the development of invasive cancer. In addition, more than 90% of patients diagnosed with invasive colorectal cancer at the local stage (has not spread to other tissues) survive at least five years after diagnosis, compared to 63% of patients diagnosed at the regional stage (tumor cells in surrounding lymph nodes or other tissues adjacent to the colon or rectum), and fewer than 10% of patients diagnosed at the distant stage (tumor cells have spread to other parts of the body).



Stage at diagnosis changed very little in Montana in the five-year intervals between 1980-1984 and 2000-2004. Colorectal cancer in situ (confined to the inner wall of the colon, not extending into other layers of colon tissue) was diagnosed in 2% of cases in 1980-1984 and in 4% of cases in 2000-2004. The proportion of cases detected at distant stage has been constant at 16-17%. The proportions of cases detected at local and regional stages have fluctuated slightly.



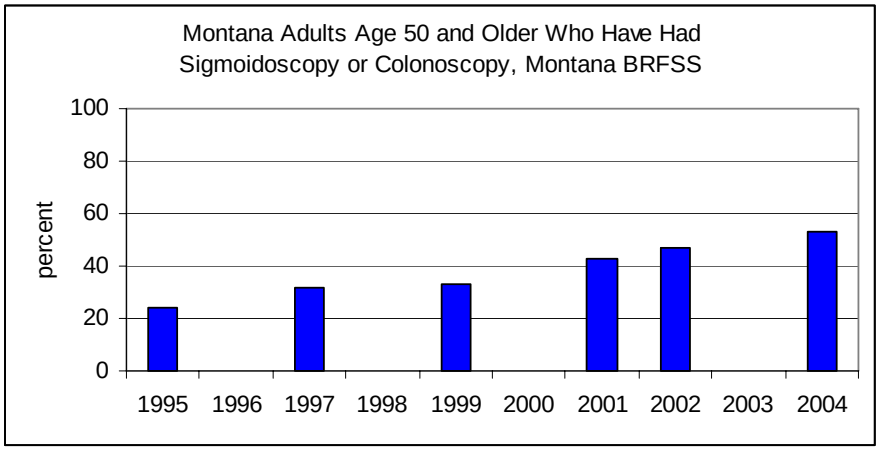
Only about a quarter of patients diagnosed with colon cancer are at increased risk by virtue of having a family history of colon cancer in a first-degree relative (parent or sibling; 20%) or a genetic syndrome conferring especially high risk (6%). The remaining three quarters of patients have no known predisposing genetic risk factors. Therefore, screening is recommended for all adults age 50 and older.[1]

[1] US Preventive Services Task Force. Screening for Colorectal Cancer. http://www.ahrq.gov/clininc/3rduspstf/colorectal/colorr/htm

The US Preventive Services Task Force is charged with performing rigorous reviews of evidence of the efficacy and risk/benefit balance of screening and other preventive practices. The Task Force published recommendations for screening for colorectal cancer in 2002.[2] The recommendations were based on a stringent review of published clinical trials and consideration of the recommendations of the National Cancer Institute,[3] the American Society of Colon and Rectal Surgeons,[4] the American Academy of Family Physicians,[5] and the American Cancer Society.[6]

For adults age 50 and older at average risk for colon cancer, recommendations include annual fecal occult blood test, and flexible sigmoidoscopy every five years or colonoscopy every 10 years. Positive fecal occult blood test or positive sigmoidoscopy should be followed up with colonoscopy. Individuals at increased risk due to a family history of colon cancer or polyps should, in consultation with their health care provider, consider colonoscopy earlier than age 50 and at shorter intervals. Individuals at high risk due to inflammatory bowel disease or who have genetic risk factors such as familial polyposis should, in consultation with their health care provider, begin colonoscopy early in adulthood and continue at frequent intervals.

All three modes of screening (fecal occult blood test, sigmoidoscopy, and colonoscopy) are widely available, but only 54% of adults age 50 and older in the US report that they have ever had a colonoscopy or sigmoidoscopy.[7] Although the proportion of the population of Montana age 50 and older who report having ever had a sigmoidoscopy or colonoscopy increased from 24% in 1995 to 53% in 2004, nearly half have not had such an exam.[8]



The public health literature suggests there are four main barriers to colonoscopy: fear of the procedure,[9] cost or no insurance coverage,[10] lack of access to screening services,[11] and lack of provider encouragement.[12] It is important for all age-eligible adults to take advantage of screening because a substantial proportion of colon cancers may be prevented by the discovery and treatment of precancerous lesions.

[2] http://www.ahrq.gov/clinic/3rduspstf/colorectal/colorr.htm
[3] http://www.cancer.gov/cancertopics/wyntk/colon-and-rectum/allpages/print
[4] http://www.fascrs.org/displaycommon.cfm?an=1&subarticlenbr=229
[5] http://familydoctor.org/556.xml
[6] *CA: A Cancer Journal for Clinicians*, 2001, 51:44-54
[7] http://apps.nccd.cdc.gov/brfss/list.asp?cat=CC&yr=2004&qkey=4425&state=All
[8] http://www.cdc.gov/brfss/
[9] Zimmerman et al., 2006, *J Urban Health* 83:221-230; Wee et al., 2005, *Prev Med* 41:23-29; Subramanian et al., 2004, *Prev Med* 38:536-550.
[10] Meissner et al., 2006, *Cancer Epidemiol Biomarkers Prev* 15:389-394.
[11] Golder et al., *Int J Colorectal Dis* July 4, 2006, 3pub; Meissner et al., 2006, *ibid*.
[12] Messina et al., 2005, *Am J Prev Med* 28:439-446; Finney et al., 2004, *Prev Med* 38:258-268; Subramanian et al., 2004, *ibid*.; Levy et al., 2006, *Am J Prev Med* 31:193-201.

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